2014 WL 1271976 (Ill.Cir.Ct.) (Trial Pleading)
Circuit Court of Illinois.
County Department
Law Division
Cook County

Denise BERENGUER, as Independent Administrator of the Estate of Odila Berenguer, Deceased, Plaintiff,
v.
CENTER HOME FOR HISPANIC **ELDERLY**, LLC, an Illinois Limited Liability Company d/b/a Center Home for Hispanic **Eldery**; Premier Healthcare Management, LLC; Angel Aguilar; Patricia Correa; and Maura Osorto, RN, Defendants.

No. 2014-L-003078.
March 14, 2014.

Complaint At Law

Levin & Perconti, Patricia L. Gifford, Katherine M. Moorhouse, 325 North LaSalle Street, Suite 450, Chicago, IL 60654, 312 332-2872, 312-332-3112 - fax, Attorney No. 55019, for the plaintiff.

The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** through her attorneys, LEVIN & PERCONTI, complains against the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY; PREMIER HEALTHCARE MANAGEMENT, LLC, an Illinois Limited Liability Company; ANGEL AGUILAR; PARTICIA CORREA;** and **MAURA OSORTO, RN,** as follows:

COUNT I

Berenguer v. Center Home for Hispanic Elderly, LLC (Statutory Action – Nursing Home Care Act – Survival)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** brings this action pursuant to the provisions of 210 ILCS 45/1/1/101 et seq., known as the Illinois Nursing Home Care Act.

3. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** brings this action pursuant to the provisions of 755 ILCS 5/27-6 *et seq.*, commonly known as the Illinois Survival Act.

4. **ODILA BERENGUER** (hereinafter **"ODILA"**) was born on XX/XX/1927.

5. **ODILA** died on October 14, 2012.

6. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY ("the Facility")** from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

7. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY** (hereinafter **"CENTER HOME FOR HISPANIC ELDERLY"**), owned, operated and/or managed the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

8. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC,** was the licensee of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

9. At all times relevant to this Complaint, there was in full force and effect, a statute known as the **Nursing Home Care Act,** as amended ("the Act"), *210 ILCS 45/1-101, et seq.*

10. At all times relevant to this Complaint, **the Facility** operated and owned by the Defendant, was a **"facility"** as defined by **45/1-113** of the Act and was subject to the requirements of the Act and the regulations of the Illinois Department of Public Health promulgated pursuant to the Act.

11. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** received payment from Medicaid and/or Medicare to provide nursing home care and treatment and related services, and was thus subject to the requirements of 42 U.S.C. Sec. 1396r (1990), as amended by the Omnibus Budget Reconciliation Act of 1987 (**OBRA**') and Volume 42, Code of Federal Regulations, Part 483 setting forth Medicare and Medicaid Requirements for Long Term Facilities (**'OBRA REGULATIONS'),** as effective on October 1, 1990.

12. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

13. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, knew or should have known that **ODILA** required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

14. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

15. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

16. The Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, was under a statutory obligation not to violate the rights of any resident of **the Facility,** including the obligation not to abuse or **neglect** any resident as provided by the Act as follows:
An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 210 ILCS 45/2-107.

"Abuse" means any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility. 210 ILCS 45/1-103.

"Neglect" means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident. 210 ILCS 45/1-117.

17. The Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, breached its duty to exercise reasonable care and otherwise acted negligently in one or more of the following ways:

a) In violation of §483.13(b) and (c) of the OBRA REGULATIONS, failed to protect ODILA from abuse and neglect by failing to appropriately develop, implement and revise a care plan to address ODILA's risk for the development and deterioration of pressure sores;

b) In violation of §483.15(a) of the OBRA REGULATIONS, failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including ODILA, in full recognition of his individuality;

c) In violation of §483.13(b) and 483.20(b) of the OBRA REGULATIONS, failed to appropriately assess ODILA's overall clinical condition, skin integrity and risk for the development and worsening of pressure sores, upon admission to the facility;

d) In violation of §483.20(g) of the OBRA REGULATIONS, failed to accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

e) In violation of §483.20(h) of the OBRA REGULATIONS, failed to have adequately trained nursing staff conduct and coordinate ODILA's assessments;

f) In violation of §483.20(k) of the OBRA REGULATIONS, failed to objectively observe, assess and evaluate changes in ODILA's condition including, but not limited to, ODILA's skin integrity;

g) In violation of §483.25(a) of the OBRA REGULATIONS, failed to provide the necessary care and services to prevent a decline in ODILA's abilities to perform activities of daily living;

h) In violation of §483.25(c)(1) and 483.25(c)(2) of the OBRA REGULATIONS, failed to provide necessary treatment and services to avoid the development of pressure sores, promote healing of pressure sores, and prevent infection and development of new pressure sores;

i) In violation of §483.25 of the OBRA REGULATIONS, failed to administer the facility in a manner to attain or maintain the highest practical, physical, mental and psycho social well-being of each resident, including ODILA;

j) In violation of §483.65(a) of the OBRA REGULATIONS, failed to have a proper infection control program that investigates, controls and prevents infection in the facility;

k) In violation of §483.75(b) of the OBRA REGULATIONS, failed to operate and provide services in compliance with all applicable professional standards by including, but not limited to, inadequate documentation in ODILA's clinical record, failure to update her care plan and failure to institute appropriate nursing interventions to promote skin integrity;

I) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a), failed to provide ODILA with the necessary care and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being in accordance with ODILA's comprehensive assessment and plan of care;

m) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a)(1), failed to provide ODILA with appropriate restorative and rehabilitative measures to meet her individual needs;

n) In violation of 77 III. Admin. Code, Ch. I, §300.1210(a)(4), failed to assist and encourage ODILA so that her abilities in daily living activities did not diminish;

o) In violation of 77 Ill. Admin. Code, Ch I, §300.1210(b)(3), failed to provide objective observations of changes in ODILA's condition, as a means for analyzing and determining the care required and the need for further medical evaluation and treatment;

p) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(b)(5), failed to provide ODILA the necessary care and services to promote healing, prevent infection and prevent pressure sores from developing;

q) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(b)(6), failed to take all necessary precautions to assure that ODILA's environment remained as free of accident hazards as possible;

r) In violation of 77 Ill. Admin. Code, Ch. I, §300.1220(b)(3), failed to develop, implement and revise an up-to-date care plan for ODILA based on her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;

s) In violation of 77 Ill. Admin. Code, Ch. I, §300.1810(b), failed to accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

t) In violation of 77 Ill. Admin. Code, Ch. I, §300.3240 failed to protect ODILA from abuse and/or **neglect**;

u) Failed to protect ODILA from abuse and **neglect**;

v) Failed to develop, implement and revise an up-to-date care plan to meet ODILA's needs including, but not limited to, her risk for the development and deterioration of pressure sores;

w) Failed to appropriately assess ODILA's risk for the development of pressure sores and the worsening of existing pressure sores;

x) Failed to provide appropriate medical care to ODILA when it was known or should have been known that such care was needed;

y) Failed to timely provide preventative measures including, but not limited to, adequate turning and repositioning assistance and pressure relief surfaces to prevent the development and progression of pressure sores;

z) Failed to properly reposition and turn ODILA and apply/utilize pressure relieving measures to relieve existing pressure sores and prevent future pressures sores from developing;

aa) Failed to timely and appropriately re-assess ODILA upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

bb) Failed to timely and appropriately revise ODILA's care plan upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

cc) Failed to accurately document ODILA'S pressure sore progression and the trea tment administered for ODILA'S pressure sores;

dd) Failed to try new approaches to treat ODILA'S worsening pressure sores; and

ee) Failed to have a proper infection control program that investigates controls and prevents infection in the facility.

18. The Nursing Home Care Act, as amended, provides as follows:
The owner and licensee are liable to a resident for any intentional or negligent act or omission of their agency or employees which injures the residents. (210 ILCS 45/3-601).

19. The Nursing Home Care Act, as amended, provides as follows:
The licensee shall pay the actual damages, and costs and attorneys' fees to a facility resident whose rights, as specified in part 1 of the Article 2 of this Act, are violated. (210 ILCS 45/3-602).

20. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

21. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries of a personal and pecuniary nature including, but not limited to, hospital, medical and related expenses, disability and disfigurement, pain and suffering, physical and emotional trauma, and a decline in **ODILA'S** level of dignity, self-respect and individuality; and **ODILA** would have been entitled to receive compensation from Defendant for these injuries had she survived. Further, **ODILA'S** estate was diminished by virtue of the medical and hospital expenses that were incurred.

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY,** in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00),** plus attorney's fees and costs as provided for by Statute.

COUNT II

Berenguer v. Center Home for Hispanic Elderly, LLC (Negligence – Survival)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER,** Deceased, brings this action pursuant to the provisions of 755 ILCS 5/27-6 *et seq.*, commonly known as the Illinois Survival Act.

3. **ODILA BERENGUER** (hereinafter **"ODILA"**) was born on XX/XX/1927.

4. **ODILA** died on October 14, 2012.

5. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY ("the Facility")** from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

6. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC: ELDERLY** (hereinafter **"CENTER HOME FOR HISPANIC ELDERLY"),** owned, operated and/or managed the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

7. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC,** was the licensee of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

8. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

9. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, knew or should have known that ODILA required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

10. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

11. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

12. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, had a duty to exercise the care required of a nursing home in the same or similar circumstances.

13. Notwithstanding, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, was negligent in the care and treatment of **ODILA** by one or more of the following negligent acts or omissions:

a) In violation of §483.13(b) and (c) of the OBRA REGULATIONS, failed to protect ODILA from abuse and neglect by failing to appropriately develop, implement and revise a care plan to address ODILA's risk for the development and deterioration of pressure sores;

b) In violation of §483.15(a) of the OBRA REGULATIONS, failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including ODILA, in full recognition of his individuality;

c) In violation of §483.13(b) and 483.20(b) of the OBRA REGULATIONS, failed to appropriately assess ODILA's overall clinical condition, skin integrity and risk for the development and worsening of pressure sores, upon admission to the facility;

d) In violation of §483.20(g) of the OBRA REGULATIONS, failed to accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

e) In violation of §483.20(h) of the OBRA REGULATIONS, failed to have adequtately trained nursing staff conduct and coordinate ODILA's assessments;

f) In violation of §483.20(k) of the OBRA REGULATIONS, failed to objectively observe, assess and evaluate changes in ODILA's condition including, but not limited to, ODILA's skin integrity;

g) In violation of §483.25(a) of the OBRA REGULATIONS, failed to provide the necessary care and services to prevent a decline in ODILA's abilities to perform activities of daily living;

h) In violation of §§483.25(c)(1) and 483.25(c)(2) of the OBRA REGULATIONS, failed to provide necessary treatment and services to avoid the development of pressure sores, promote healing of pressure sores, and prevent infection and development of new pressure sores;

i) In violation of §483.25 of the OBRA REGULATIONS, failed to administer the facility in a manner to attain or maintain the highest practical, physical, mental and psycho social well-being of each resident includin ODILA;

j) In violation of §483.65(a) of the OBRA REGULATIONS, failed to have a proper infection control program that investigates, controls and prevents infection in the facility;

k) In violation of §483.75(b) of the OBRA REGULATIONS, failed to operate and provide services in compliance with all applicable professional standards by including, but not limited to, inadequate documentation in ODILA's clinical record, failure to update her care plan and failure to institute appropriate nursing interventions to promote skin integrity;

I) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a), failed to provide ODILA with the necessary care and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being in accordance with ODILA's comprehensive assessment and plan of care;

m) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a)(1), failed to provide ODILA with appropriate restorative and rehabilitative measures to meet her individual needs;

n) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a)(4), failed to assist and encourage ODILA so that her abilities in daily living activities did not diminish;

o) In violation of 77 Ill. Admin. Code, Ch I, §300.1210(b)(3), failed to provide objective observations of changes in ODILA's condition, as a means for analyzing and determining the care required and the need for further medical evaluation and treatment;

p) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(b)(5), failed to provide ODILA the necessary care and services to promote healing, prevent infection and prevent pressure sores from developing;

q) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(b)(6), failed to take all necessary precautions to assure that ODILA's environment remained as free of accident hazards as possible;

r) In violation of 77 Ill. Admin. Code, Ch. I, §300.1220(b)(3), failed to develop, implement and revise an up-to-date care plan for ODILA based on her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;

s) In violation of 77 Ill. Admin. Code, Ch. I, §300.1810(b), failed to accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

t) In violation of 77 Ill. Admin. Code, Ch. I, §300.3240 failed to protect ODILA from abuse and/or neglect;

u) Failed to protect ODILA from abuse and neglect;

v) Failed to develop, implement and revise an up-to-date care plan to meet ODILA's needs including, but not limited to, her risk for the development and deterioration of pressure sores;

w) Failed to appropriately assess ODILA's risk for the development of pressure sores and the worsening of existing pressure sores;

x) Failed to provide appropriate medical care to ODILA when it was known or should have been known that such care was needed;

y) Failed to timely provide preventative measures including, but not limited to, adequate turning and repositioning assistance and pressure relief surfaces to prevent the development and progression of pressure sores;

z) Failed to properly reposition and turn ODILA and apply/utilize pressure relieving measures to relieve existing pressure sores and prevent future pressures sores from developing;

aa) Failed to timely and appropriately re-assess ODILA upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

bb) Failed to timely and appropriately revise ODILA's care plan upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

cc) Failed to accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

dd) Failed to try new approaches to treat ODILA'S worsening pressure sores; and

ee) Failed to have a proper infection control program that investigates, controls and prevents infection in the facility.

14. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

15. As a direct and proximate result of one or more of the Defendant's negligent acts or omissions, **ODILA** suffered injuries of a personal and pecuniary nature including, but not limited to, hospital, medical and related expenses, disability and disfigurement, pain and suffering, physical and emotional trauma, and a decline in **ODILA'S** level of dignity, self-respect and individuality; and **ODILA** would have been entitled to receive compensation from Defendant for these injuries had she survived. Further, **ODILA'S** estate was diminished by virtue of the medical and hospital expenses that were incurred.

16. Attached to this Complaint as “Exhibit B” is the Affidavit of the Attorney in this cause and Health Professional's Report, filed pursuant to 735 ILCS 5/2-622(a)(1).

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **CENTER HOME**

FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY, in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00).**

COUNT III

Berenguer v. Center Home for Hispanic Elderly, LLC (Negligence – Wrongful Death)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the Estate of **ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** brings this action pursuant to the provisions of 740 ILCS 180/1, *et seq.*, commonly known as the Illinois Wrongful Death Act.

3. **ODILA BERENGUER** (hereinafter **"ODILA")** was born on XX/XX/1927.

4. **ODILA** died on October 14, 2012.

5. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY** (**"the Facility"**) from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

6. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY** (hereinafter **"CENTER HOME FOR HISPANIC ELDERLY"),** owned, operated and/or managed the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

7. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC,** was the licensee of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

8. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

9. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, knew or should have known that **ODILA** required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

10. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

11. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

12. At all times relevant to this Complaint, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, had a duty to exercise the care required of a nursing home in the same or similar circumstances.

13. Notwithstanding, the Defendant, **CENTER HOME FOR HISPANIC ELDERLY,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, was negligent in the care and treatment of ODILA by one or more of the following negligent acts or omissions:

a) In violation of §483.13(b) and (c) of the OBRA REGULATIONS, failed to protect ODILA from abuse and neglect by failing to appropriately develop, implement and revise a care plan to address ODILA's risk for the development and deterioration of pressure sores;

b) In violation of §483.15(a) of the OBRA REGULATIONS, failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including ODILA, in full recognition of his individuality;

c) In violation of §483.13(b) and 483.20(b) of the OBRA REGULATIONS, failed to appropriately assess ODILA's overall clinical condition, skin integrity and risk for the development and worsening of pressure sores, upon admission to the facility;

d) In violation of §483.20(g) of the OBRA REGULATIONS, failed to accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

e) In violation of §483.20(h) of the OBRA REGULATIONS, failed to have adequately trained nursing staff conduct and coordinate ODILA's assessments;

f) In violation of §483.20(k) of the OBRA REGULATIONS, failed to objectively observe, assess and evaluate changes in ODILA's condition including, but not limited to, ODILA's skin integrity;

g) In violation of §483.25(a) of the OBRA REGULATIONS, failed to provide the necessary care and services to prevent a decline in ODILA's abilities to perform activities of daily living;

h) In violation of §§483.25(c)(1) and 483.25(c)(2) of the OBRA REGULATIONS, failed to provide necessary treatment and services to avoid the development of pressure sores, promote healing of pressure sores, and prevent infection and development of new pressure sores;

i) In violation of §483.25 of the OBRA REGULATIONS, failed to administer the facility in a manner to attain or maintain the highest practical, physical, mental and psycho social well-being of each resident, including ODILA;

j) In violation of §483.65(a) of the OBRA REGULATIONS, failed to have a proper infection control program that investigates, controls and prevents infection in the facility;

k) In violation of §483.75(b) of the OBRA REGULATIONS, failed to operate and provide services in compliance with all applicable professional standards by including, but not limited to, inadequate documentation in ODILA's clinical record, failure to update her care plan and failure to institute appropriate nursing interventions to promote skin integrity;

I) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a), failed to provide ODILA with the necessary care and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being in accordance with ODILA's comprehensive assessment and plan of care;

m) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a)(1), failed to provide ODILA with appropriate restorative and rehabilitative measures to meet her individual needs;

n) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a)(4), failed to assist and encourage ODILA so that her abilities in daily living activities did not diminish;

o) In violation of 77 Ill. Admin. Code, Ch I, §300.1210(b)(3), failed to provide objective observations of changes in ODILA's condition, as a means for analyzing and determining the care required and the need for further medical evaluation and treatment;

p) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(b)(5), failed to provide ODILA the necessary care and services to promote healing, prevent infection and prevent pressure sores from developing;

q) In violation of 77 Ill. Admin. Code, Ch. Ill, §300.1210(b)(6), failed take all necessary precautions to assure that ODILA's environment remained as free of accident hazards as possible;

r) In violation of 77 III. Admin. Code, Ch. I, §300.1220(b)(3), failed to develop, implement and revise an up-to-date care plan for ODILA based on her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;

s) In violation of 77 Ill. Admin. Code, Ch. I, §300.1810(b), failed to accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

t) In violation of 77 Ill. Admin. Code, Ch. I, §300.3240 failed to protect ODILA from abuse and/or **neglect**;

u) Failed to protect ODILA from abuse and neglect;

v) Failed to develop, implement and revise an up-to-date care plan to meet ODILA's needs including, but not limited to, her risk for the development and deterioration of pressure sores;

w) Failed to appropriately assess ODILA's risk for the development of pressure sores and the worsening of existing pressure sores;

x) Failed to provide appropriate medical care to ODILA when it was known or should have been known that such care was needed;

y) Failed to timely provide preventative measures including, but not limited to, adequate turning and repositioning assistance and pressure relief surfaces to prevent the development and progression of pressure sores;

z) Failed to properly reposition and turn ODILA and apply/utilize pressure relieving measures to relieve existing pressure sores and prevent future pressures sores from developing;

aa) Failed to timely and appropriately re-assess ODILA upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

bb) Failed to timely and appropriately revise ODILA's care plan upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

cc) Failed to accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

dd) Failed to try new approaches to treat ODILA'S worsening pressure sores; and

ee) Failed to have a proper infection control program that investigates, controls and prevents infection in the facility.

14. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

15. All of **ODILA'S** next of kin suffered injuries as a result of her death including, but not limited to, the loss of companionship and society and grief, sorrow and mental anguish. Further, **ODILA'S** estate was diminished by virtue of the medial and hospital expenses that were incurred.

16. **ODILA** left surviving her, various persons who were here next of kin, including, but not limited to, the following individuals:
a. Denise Bererguer (daughter);

b. Lilliana Caraballo-Butcher (daughter); and

c. Miguel Laboy (son).

17. Attached to this Complaint as "Exhibit B" is the Affidavit of the Attorney in this cause and Health Professional's Report, filed pursuant to 735 ILCS 5/2-622(a)(1).

WHEREFORE, the Plaintiff, DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased, prays that this Honorable Court enter a judgment against the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY,** in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00).**

COUNT IV

Berenguer v. Premier Heathcare Management, LLC (Negligence – Survival)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** brings this action pursuant to the provisions of 755 ILCS 5/27-6 *et seq.*, commonly known as the Illinois Survival Act.

3. **ODILA BERENGUER** (hereinafter **"ODILA")** was born on XX/XX/1927.

4. **ODILA** died on October 14, 2012.

5. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY ("the Facility")** from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

6. At all times relevant to this Complaint, the Defendant, **PREMIER HEALTHCARE MANAGEMENT, LLC, an Illinois Limited Liability Company** (hereinafter **"PREMIER HEALTHCARE"**), owned, operated and/or managed the long-term

care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

7. At all times relevant to this Complaint, the Defendant, **PREMIER HEALTHCARE,** was the management company of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

8. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

9. At all times relevant to this Complaint, the Defendant, **PREMIER HEALTHCARE,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, knew or should have known that **ODILA** required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

10. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

11. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

12. The Defendant, **PREMIER HEALTHCARE,** as the management company, owner and/or operator of **CENTER HOME FOR HISPANIC ELDERLY,** exercised significant control over the day-to-day operations of the nursing home's business, including but not limited to, budgetary decisions, hiring and firing, staffing **the Facility,** training the staff, contracting for services with consultants, managing the finances of **the Facility,** monitoring the quality of care by the nursing staff and physicians to residents of **the Facility,** and providing financial resources for nursing and medical supplies.

13. In providing services in the day-to-day operations of **CENTER HOME FOR HISPANIC ELDERLY** the Defendant, **PREMIER HEALTHCARE,** through its owners, managers, officers, employees and agents had a duty to exercise ordinary care.

14. During and prior to the period of **ODILA's** residency at **CENTER HOME FOR HISPANIC ELDERLY,** notwithstanding said duty, the Defendant, **PREMIER HEALTHCARE,** breached its duty to exercise ordinary care by one or more of the following negligent acts or omissions:

a) Failed to provide enough staff to care for its residents, including ODILA;

b) Overworked the staff it had by forcing them to work longer hours than they could tolerate and still provide appropriate care to the residents, including ODILA;

c) Failed to see that the nursing home was being operated in compliance with all applicable state and federal regulations;

d) Inappropriately allocated excessive funds to itself thereby draining the nursing home of the resources necessary to maintain sufficient and appropriately trained staff and supplies to prevent the development of and treat pressure sores;

e) Was aware of complaints, concerns and problems at the nursing home regarding resident care and ignored them; and

f) Inappropriately marketed the nursing home as having the ability to provide services that it was ill equipped to provide.

15. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

16. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries of a personal and pecuniary nature including, but not limited to, hospital, medical and related expenses, disability and disfigurement, pain and suffering, physical and emotional trauma, and a decline in **ODILA'S** level of dignity, self-respect and individuality; and **ODILA** would have been entitled to receive compensation from Defendant for these injuries had she survived. Further, **ODILA'S** estate was diminished by virtue of the medical and hospital expenses that were incurred.

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **PREMIER HEALTHCARE MANAGEMENT, LLC,** an Illinois Limited Liability Company, in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00).**

COUNT V

Berenguer v. Premier Healthcare Management, LLC (Negligence – Wrongful Death)

1. **DENISE B ERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUEER, Deceased,** brings this action pursuant to the provisions of 740 ILCS 180/1, *et seq.*, ccmmonly known as the Illinois Wrongful Death Act.

3. **ODILA BERENGUER** (hereinafter **"ODILA"**) was born on XX/XX/1927.

4. **ODILA** died on October 14, 2012.

5. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY ("the Facility")** from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

6. At all times relevant to this Complaint, the Defendant, **PREMIER HEALTHCARE MANAGEMENT, LLC, an Illinois Limited Liability Company** (hereinafter **"PREMIER HEALTHCARE"**), owned, operated and/or managed the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

7. At all times relevant to this Complaint, the Defendant, **PREMIER HEALTHCARE,** was the management company of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY,** located at 1401 North California Avenue in Chicago, Illinois.

8. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

9. At all times relevant to this Complaint, the Defendant, **PREMIER HEALTHCARE,** by and through its actual, implied and/or apparent agents, servants and employees, including physicians, nurses and/or other healthcare professionals, knew or should have known that **ODILA** required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

10. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

11. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

12. The Defendant, **PREMIER HEALTHCARE,** as the management company, owner and/or operator of **CENTER HOME FOR HISPANIC ELDERLY,** exercised significant control over the day-to-day operations of the nursing home's business, including but not limited to, budgetary decisions, hiring and firing, staffing **the Facility,** training the staff, contracting for services with consultants, managing the finances of **the Facility,** monitoring the quality of care by the nursing staff and physicians to residents of **the Facility,** and providing financial resources for nursing and medical supplies.

13. In providing services in the day-to-day operations of **CENTER HOME FOR HISPANIC ELDERLY** the Defendant, **PREMIER HEALTHCARE,** through its owners, managers, officers, employees and agents had a duty to exercise ordinary care.

14. During and prior to the period of **ODILA'S** residency at **CENTER HOME FOR HISPANIC ELDERLY, notwithstanding said duty, the Defendant, PREMIER HEALTHCARE,** breached its duty to exercise ordinary care by one or more of the following negligent acts or omissions:
a) Failed to provide enough staff to care for its residents, including ODILA;

b) Overworked the staff it had by forcing them to work longer hours than they could tolerate and still provide appropriate care to the residents, including ODILA;

c) Failed to see that the nursing home was being operated in compliance with all applicable state and federal regulations;

d) Inappropriately allocated excessive funds to itself thereby draining the nursing home of the resources necessary to maintain sufficient and appropriately trained staff and supplies to prevent the development of and treat pressure sores;

e) Was aware of complaints, concerns and problems at the nursing home regarding resident care and ignored them; and

f) Inappropriately marketed the nursing home as having the ability to provide services that it was ill equipped to provide.

15. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

16. All of **ODILA'S** next of kin suffered injuries as a result of her death including, but not limited to, the loss of companionship and society and grief, sorrow and mental anguish. Further, **ODILA'S** estate was diminished by virtue of the medial and hospital expenses that were incurred.

17. **ODILA** left surviving her, various persons who were here next of kin, including, but not limited to, the following individuals:
a. Denise Berenguer (daughter);

b. Lilliana Caraballo-Butcher (daughter); and

c. Miguel Laboy (son).

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **PREMIER HEALTHCARE MANAGEMENT, LLC, an Illinois Limited Liability Company,** in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00).**

COUNT VI

Berenguer v. ANGEL AGUILAR (Negligence – Survival)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** brings this action pursuant to the provisions of 755 ILCS 5/27-6 et seq., commonly known as the Illinois Survival Act.

3. **ODILA BERENGUER** (hereinafter **"ODILA")** was born on XX/XX/1927.

4. **ODILA** died on October 14, 2012.

5. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY ("the Facility")** from approximately March 22, 2012 through August 2 2012, with intermittent hospitalizations.

6. At all times relevant to this Complaint, the Defendant, **ANGEL AGUILAR,** was the Nursing Home Administrator of **CENTER HOME FOR HISPANIC ELDERLY.**

7. At all times relevant to this Complaint, the Defendant, **ANGEL AGUILAR,** was ting as an actual, apparent and/or implied agent, servant, and/or employee of the Defendant, **ENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability ompany d/b/a CENTER HOME FOR HISPANIC ELDERLY.**

8. At all times relevant to this Complaint, the Defendant, **ANGEL AGUILAR,** was acting as within the scope of her employment and/or agency relationship with the Defendant, **CENTER HOME FOR HISPANIC ELDERLY.**

9. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

10. At all times relevant to this Complaint, the Defendant, **ANGEL AGUILAR,** knew or should have known that *ODILA* was at risk for the development and deterioration of pressure sores and that she required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

11. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

12. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

13. Pursuant to §483.75(d)(2)(ii) of the OBRA Regulations, as Administrator of the Facility, **ANGEL AGUILAR** was responsible for the management of the Facility.

14. Pursuant to 210 ILCS 45/1-105, as Administrator of the Facility, **ANGEL AGUILAR** was charged with the general administration and supervision of the Facility.

15. Pursuant to 77 Illinois Administrative Code, Ch. I §300.330, as Administrator of the Facility, **ANGEL AGUILAR** was the person who was directly responsible for the operation and administration of the Facility.

16. At all times relevant to this Complaint, it was the duty of the Defendant, **ANGEL AGUILAR,** to use the skill and care ordinarily used by a reasonably well-qualified nursing home administrator in the same or similar circumstances.

17. Notwithstanding, the Defendant, **ANGEL AGUILAR,** breached her duty aforesaid and was negligent as a result of one or more of the following negligent acts or omissions:

a) In violation of 77 IL Adm. Code, Ch .1 §300.3240, failed to administer the facility in a manner that protected ODILA from abuse and neglect;

b) In violation of §483.25 of the OBRA REGULATIONS, failed to administer the facility in a manner that ensured the staff provided the necessary care and services to attain or maintain ODILA'S highest practicable physical, mental and psychosocial well-being in accordance with her care plan and comprehensive assessment;

c) In violation of §483.13(b) of the OBRA REGULATIONS, failed to administer the facility in a manner that protected ODILA from neglect;

d) In violation of 77 IL Adm. Code, Ch. I, §300.1210 a), failed to administer the facility in a manner that provided adequate and properly supervised care to meet ODILA'S total nursing and personal care needs;

e) Failed to administer the facility in a manner that ensured the staff appropriately implemented and followed a care plan to address ODILA'S needs;

f) Failed to administer the facility in a manner that ensured the staff properly supervised and monitored ODILA while he was in the facility;

g) Failed to administer the facility in a manner that ensured the staff provided adequate and properly supervised care as needed by ODILA to prevent the development and deterioration of her pressure sores;

h) Failed to administer the facility and provide services at the facility in compliance with all applicable Federal, State, and local laws, regulations and codes and with accepted professional standards and principles that apply to professionals providing services in such a facility;

i) Failed to administer the facility with a sufficient number of properly trained and supervised nurses and certified nursing assistants to provide the required care to the residents including, ODILA; and,

j) Otherwise failed to administer the facility in a manner that ensured the staff provided adequate medical care, personal care, maintenance, and treatment.

18. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

19. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries of a personal and pecuniary nature including, but not limited to, hospital, medical and related expenses, disability and disfigurement, pain and suffering, physical and emotional trauma, and a decline in **ODILA'S** level of dignity, self-respect and individuality; and **ODILA** would have been entitled to receive compensation from Defendant for these injuries had she survived. Further, **ODILA'S** estate was diminished by virtue of the medical and hospital expenses that were incurred.

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **ANGEL AGUILAR,** in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00).**

COUNT VII

Berenguer v. ANGEL AGUILAR (Negligence – Wrongful Death)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** brings this action pursuant to the provisions of 740 ILCS 180/1 et seq., commonly known as the Illinois Wrongful Death Act.

3. **ODILA BERENGUER** (hereinafter **"ODILA")** was born on XX/XX/1927.

4. **ODILA** died on October 14, 2012.

5. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY (the Facility")** from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

6. At all times relevant to this Complaint, the Defendant, **ANGEL AGUILAR,** was the Nursing Home Administrator of **CENTER HOME FOR HISPANIC ELDERLY.**

7. At all times relevant to this Complaint, the Defendant, **ANGEL AGUILAR,** was acting as an actual, apparent and/or implied agent, servant, and/or employee of the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY.**

8. At all times relevant to this Complaint, the Defendant, **ANGEL AGUILAR,** was acting within the scope of her employment and/or agency relationship with the Defendant, **CENTER HOME FOR HISPANIC ELDERLY.**

9. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

10. At all times relevant to this Complaint, the Defendant, **ANGEL AGUILAR,** knew or should have known that **ODILA** was at risk for the development and deterioration of pressure sores and that she required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

11. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

12. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

13. Pursuant to §483.75(d)(2)(ii) of the OBRA Regulations, as Administrator of the Facility, **ANGEL AGUILAR** was responsible for the management of the Facility.

14. Pursuant to 210 ILCS 45/1-105, as Administrator of the Facility, **ANGEL AGUILAR** was charged with the general administration and supervision of the Facility.

15. Pursuant to 77 Illinois Administrative Code, Ch. I §300.330, as Administrator of the Facility, **ANGEL AGUILAR** was the person who was directly responsible for the operation and administration of the Facility.

16. At all times relevant to this Complaint, it was the duty of the Defendant, **ANGEL AGUILAR,** to use the skill and care ordinarily used by a reasonably well-qualified nursing home administrator in the same or similar circumstances.

17. Notwithstanding, the Defendant, **ANGEL AGUILAR,** breached her duty aforesaid and was negligent as a result of one or more of the following negligent acts or omissions:

a) In violation of 77 IL Adm. Code, Ch.I §300.3240, failed to administer the facility in a manner that protected ODILA from abuse and neglect;

b) In violation of §483.25 of the OBRA REGULATIONS, failed to administer the facility in a manner that ensured the staff provided the necessary care and services to attain or maintain ODILA'S highest practicable physical, mental and psychosocial well-being in accordance with her care plan and comprehensive assessment;

c) In violation of §483.13(b) of the OBRA REGULATIONS, failed to administer the facility in a manner that protected ODILA from neglect;

d) In violation of 77 IL Adm. Code, Ch. I, §300.1210 a), failed to administer the facility in a manner that provided adequate and properly supervised care to meet ODILA'S total nursing and personal care needs;

e) Failed to administer the facility in a manner that ensured the staff appropriately implemented and followed a care plan to address ODILA'S needs;

f) Failed to administer the facility in a manner that ensured the staff properly supervised and monitored ODILA while he was in the facility;

g) Failed to administer the facility in a manner that ensured the staff provided adequate and properly supervised care as needed by ODILA to prevent the development and deterioration of her pressure sores;

h) Failed to administer the facility and provide services at the facility in compliance with all applicable Federal, State, and local laws, regulations and codes and with accepted professional standards and principles that apply to professionals providing services in such a facility;

i) Failed to administer the facility with a sufficient number of properly trained and supervised nurses and certified nursing assistants to provide the required care to the residents including, ODILA; and,

j) Otherwise failed to administer the facility in a manner that ensured the staff provided adequate medical care, personal care, maintenance, and treatment.

18. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

19. All of **ODILA'S** next of kin suffered injuries as a result of her death including, but not limited to, the loss of companionship and society and grief, sorrow and mental anguish. Further, **ODILA'S** estate was diminished by virtue of the medial and hospital expenses that were incurred.

20. **ODILA** left surviving her, various persons who were here next of kin, including, but not limited to, the following individuals:
a. Denise Berenguer (daughter);

b. Lilliana Caraballo-Butcher (daughter); and

c. Miguel Laboy (son).

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **ANGEL AGUILAR,** in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00).**

COUNT VIII

Berenguer v. Patricia Correa (Negligence – Survival)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** brings this action pursuant to the provisions of 755 ILCS 5/27-6 *et seq.*, commonly known as the Illinois Survival Act.

3. **ODILA BERENGUER** (hereinafter **"ODILA")** was born on XX/XX/1927.

4. **ODILA** died on October 14, 2012.

5. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY (“the Facility”)** from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

6. At all times relevant to this Complaint, the Defendant, **PATRICA CORREA,** was the Nursing Home Administrator of **CENTER HOME FOR HISPANIC ELDERLY.**

7. At all times relevant to this Complaint, the Defendant, PATRICA CORREA, was acting as an actual, apparent and/or implied agent, servant, and/or employee of the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY.**

8. At all times relevant to this Complaint, the Defendant, **PATRICA CORREA,** was acting within the scope of her employment and/or agency relationship with the Defendant, **CENTER HOME FOR HISPANIC ELDERLY.**

9. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

10. At all times relevant to this Complaint, the Defendant, **PATRICIA CORREA,** knew or should have known that **ODILA** was at risk for the development and deterioration of pressure sores and that she required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

11. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

12. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

13. Pursuant to §483.75(d)(2)(ii) of the OBRA Regulations, as Administrator of the Facility, **PATRICIA CORREA** was responsible for the management of the Facility.

14. Pursuant to 210 ILCS 45/1-105, as Administrator of the Facility, **PATRICIA CORREA** was charged with the general administration and supervision of the Facility.

15. Pursuant to 77 Illinois Administrative Code, Ch. I §300.330, as Administrator of the Facility, **PATRICIA CORREA** was the person who was directly responsible for the operation and administration of the Facility.

16. At all times relevant to this Complaint, it was the duty of the Defendant, **PATRICIA CORREA,** to use the skill and care ordinarily used by a reasonably well-qualified nursing home administraton in the same or similar circumstances.

17. Notwithstanding, the Defendant, **PATRICIA CORREA,** breached her duty aforesaid and was negligent as a result of one or more of the following negligent acts or omissions:
a) In violation of 77 IL. Adm. Code, Ch.1 §300.3240, failed to amnser the facility in a manner that protected ODILA from abuse and neglect;

b) In violation of §483.25 of the OBRA REGULATIONS, failed to administer the facility in a manner that ensured the staff provided the necessary care and services to attain or maintain ODILA'S highest practicable physical, mental and psychosocial well-being in accordance with her care plan and comprehensive assessment;

c) In violation of §483.13(b) of the OBRA REGULATIONS, failed to administer the facility in a manner that protected ODILA from neglect;

d) In violation of 77 IL Adm. Code, Ch.I, §300.1210 a), failed to administer the facility in a manner that provided adequate and properly supervised care to meet ODILA'S total nursing and personal care needs;

e) Failed to administer the facility in a manner that ensured the staff appropriately implemented and followed a care plan to address ODILA'S n needs;

f) Failed to administer the facility in a manner that ensured the staff properly supervised and monitored ODILA while he was in the facility;

g) Failed to administer the facility in a manner that ensured the staff provided adequate and properly supervised care as needed by ODILA to prevent the development and deterioration of her pressure sores;

h) Failed to administer the facility and provide services at the facility in compliance with all applicable Federal, State, and local laws, regulations and codes and with accepted professional standards and principles that apply to professionals providing services in such a facility;

i) Failed to administer the facility with a sufficient number of properly trained and supervised nurses and certified nursing assistants to provide the required care to the residents including, ODILA; and,

j) Otherwise failed to administer the facility in a manner that ensured the staff provided adequate medical care, personal care, maintenance, and treatment.

18. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

19. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries of a personal and pecuniary nature including, but not limited to, hospital, medical and related expenses, disability and disfigurement, pain and suffering, physical and emotional trauma, and a decline in **ODILA'S** level of dignity, self-respect and individuality; and **ODILA** would have been entitled to receive compensation from Defendant for these injuries had she survived. Further, **ODILA'S** estate was diminished by virtue of the medical and hospital expenses that were incurred.

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **PATRICIA CORREA,** in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS (550,000.00).**

COUNT IX

Berenguer v. Patricia Correa (Negligence – Wrongful Death)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** brings this action pursuant to the provisions of 740 ILCS 180/1 *et seq.*, commonly known as the Illinois Wrongful Death Act.

3. **ODILA BERENGUER** (hereinafter **"ODILA"**) was born on XX/XX/1927.

4. **ODILA** died on October 14, 2012.

5. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY ("the Facility")** from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

6. At all times relevant to this Complaint, the Defendant, **PATRICA CORREA,** was the Nursing Home Administrator of **CENTER HOME FOR HISPANIC ELDERLY.**

7. At all times relevant to this Complaint, the Defendant, **PATRICA CORREA,** was acting as an actual, apparent and/or implied agent, servant, and/or employee of the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY.**

8. At all times relevant to this Complaint, the Defendant, **PATRICA CORREA,** was acting within the scope of her employment and/or agency relationship with the Defendant, **CENTER HOME FOR HISPANIC ELDERLY.**

9. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

10. At all times relevant to this Complaint, the Defendant, **PATRICIA CORREA,** knew or should have known that **ODILA** was at risk for the development and deterioration of pressure sores and that she required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

11. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

12. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

13. Pursuant to §483.75(d)(2)(ii) of the OBRA Regulations, as Administrator of the Facility, **PATRICIA CORREA** was responsible for the management of the Facility.

14. Pursuant to 210 ILCS 45/1-105, as Administrator of the Facility, **PATRICIA CORREA** was charged with the general administration and supervision of the Facility.

15. Pursuant to 77 Illinois Administrative Code, Ch.I §300.330, as Administrator of the Facility, **PATRICIA CORREA** was the person who was directly responsible for the operation and administration of the Facility.

16. At all times relevant to this Complaint, it was the duty of the Defendant, **PATRICIA CORREA,** to use the skill and care ordinarily used by a reasonably careful nursing home administrator.

17. Notwithstanding, the Defendant, **PATRICIA CORREA,** breached her duty aforesaid and was negligent as a result of one or more of the following negligent acts or omissions:
a) In violation of 77 IL Adm. Code, Ch.I §300.3240, failed to administer the facility in a manner that protected ODILA from abuse and neglect;

b) In violation of §483.25 of the OBRA REGULATIONS, failed to administer the facility in a manner that ensured the staff provided the necessary care and services to attain or maintain ODILA'S highest practicable physical, mental and psychosocial well-being in accordance with her care plan and comprehensive assessment;

c) In violation of §483.13(b) of the OBRA REGULATIONS, failed to administer the facility in a manner that protected ODILA from neglect;

d) In violation of 77 IL Adm. Code, Ch.I, §300.1210 a), failed to administer the facility in a manner that provided adequate and properly supervised care to meet ODILA'S total nursing and personal care needs;

e) Failed to administer the facility in a manner that ensured the staff appropriately implemented and followed a care plan to address ODILA'S needs;

f) Failed to administer the facility in a manner that ensured the staff properly supervised and monitored ODILA while he was in the facility;

g) Failed to administer the facility in a manner that ensured the staff provided adequate and properly supervised care as needed by ODILA to prevent the development and deterioration of her pressure sores;

h) Failed to administer the facility and provide services at the facility in compliance with all applicable Federal, State, and local laws, regulations and codes and with accepted professional standards and principles that apply to professionals providing services in such a facility;

i) Failed to administer the facility with a sufficient number of properly trained and supervised nurses and certified nursing assistants to provide the required care to the residents including, ODILA; and, j) Otherwise failed to administer the facility in a manner that ensured the staff provided adequate medical care, personal care, maintenance, and treatment.

18. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

19. All of **ODILA'S** next of kin suffered injuries as a result of her death including, but not limited to, the loss of companionship and society and grief, sorrow and mental anguish. Further, **ODILA'S** estate was diminished by virtue of the medial and hospital expenses that were incurred.

20. **ODILA** left surviving her, various persons who were here next of kin, including, but not limited to, the following individuals:
a. Denise Berenguer (daughter);

b. Lilliana Caraballo-Butcher (daughter); and

c. Miguel Laboy (son).

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **PATRICIA CORREA,** in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00).**

COUNT X

Berenguer v. Maura Osorto. RN (Negligence – Survival)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** brings this action pursuant to the provisions of 755 ILCS 5/27-6 et seq., commonly known as the Illinois Survival Act.

3. **ODILA BERENGUER** (hereinafter **"ODILA**") was born on XX/XX/1927.

4. **ODILA** died on October 14, 2012.

5. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY (the Facility")** from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

6. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** was a Registered Nurse, licensed by the State of Illinois operated under License Number XXXXXXXXX.

7. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** was employed as the Director of Nursing for **CENTER HOME FOR HISPANIC ELDERLY.**

8. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** was acting as an actual, apparent and/or implied agent, servant, and/or employee of the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY** located at 1401 North California Avenue in Chicago, Illinois.

9. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** was acting within the scope of her employment and/or agency relationship with the Defendant, **CENTER HOME FOR HISPANIC ELDERLY.**

10. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

11. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** knew or should have known that **ODILA** was at risk for the development and deterioration of pressure sores and that she required supervision and assistance with activities of daily living to ensure that she was rece.ving proper care and treatment to prevent the development and deterioration of pressure so-es.

12. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

13. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

14. Pursuant to 77 Ill. Admin. Code, Ch. I §300.1220, as the Director of Nursing, **MAURA OSORTO, RN,** had a duty to supervise and oversee the nursing services provided at **CENTER HOME FOR HISPANIC ELDERLY.**

15. At all times relevant to this Complaint, it was the duty of the Defendant, **MAURA OSORTO, RN,** to use the skill and care ordinarily used by a reasonably well-qualified director of nursing in the supervision of the nursing staff providing care and treatment to **ODILA.**

16. Notwithstanding, the Defendant, **MAURA OSORTO, RN,** breached her duty aforesaid and was negligent as a result of one or more of the following negligent acts or omissions:
a) In violation of §483.13(b) and (c) of the OBRA REGULATIONS, failed to protect ODILA from abuse and neglect by failing to ensure that the staff appropriately developed, implemented and revised a care plan to address ODILA's risk for the development and deterioration of pressure sores;

b) In violation of §483.15(a) of the OBRA REGULATIONS, failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including ODILA, in full recognition of his individuality;

c) In violation of §483.13(b) and 483.20(b) of the OBRA REGULATIONS, failed to ensure that the staff appropriately assessed ODILA's overall clinical condition, skin integrity and risk for the development and worsening of pressure sores, upon admission to the facility;

d) In violation of §483.20(g) of the OBRA REGULATIONS, failed to ensure that the staff accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

e) In violation of §483.20(h) of the OBRA REGULATIONS, failed to have adequately trained nursing staff conduct and coordinate ODILA's assessments;

f) In violation of §483.20(k) of the OBRA REGULATIONS, failed to ensure that the staff objectively observe, assess and evaluate changes in ODILA's condition including, but not limited to, ODILA's skin integrity;

g) In violation of §483.25(a) of the OBRA REGULATIONS, failed to ensure that the staff provide the necessary care and services to prevent a decline in ODILA's abilities to perform activities of daily living;

h) In violation of §§483.25(c)(1) and 483.25(c)(2) of the OBRA REGULATIONS, failed to ensure that the staff provide necessary treatment and services to avoid the development of pressure sores, promote healing of pressure sores, and prevent infection and development of new pressure sores;

i) In violation of §483.25 of the OBRA REGULATIONS, failed to ensure that the staff provided care and treatment to ODILA to allow her to attain or maintain the highest practical, physical, mental and psycho social well-being;

j) In violation of §483.65(a) of the OBRA REGULATIONS, failed to have a proper infection control program that investigates, controls and prevents infection in the facility;

k) In violation of §483.75(b) of the OBRA REGULATIONS, failed to operate and provide services in compliance with all applicable professional standards by including, but not limited to, inadequate documentation in ODILA's clinical record, failure to update her care plan and failure to institute appropriate nursing interventions to promote skin integrity;

I) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a), failed to ensure that the staff provide ODILA with the necessary care and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being in accordance with ODILA's comprehensive assessment and plan of care;

m) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a)(1), failed to ensure that the staff provide ODILA with appropriate restorative and rehabilitative measures to meet her individual needs;

n) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a)(4), failed to ensure that the staff assist and encourage ODILA so that her abilities in daily living activities did not diminish;

o) In violation of 77 Ill. Admin. Code, Ch I, §300.1210(b)(3), failed to ensure that the staff provide objective observations of changes in ODILA's condition, as a means for analyzing and determining the care required and the need for further medical evaluation and treatment;

p) In violation of 77 III. Admin. Code, Ch. I, §300.1210(b)(5), failed to ensure that the staff provide ODILA the necessary care and services to promote healing, prevent infection and prevent pressure sores from developing;

q) In violation of 77 Ill. Admin. Code, Cll. I, §500.1210(b)(6), ralied to ensure that the staff take all necessary precautions to assure that ODILA's environment remained as free of accident hazards as possible;

r) In violation of 77 III. Admin. Code, Ch. I, §300.1220(b)(3), failed to 46 **ensure that the staff develop, implement and revise an up-to-date care plan for ODILA based on her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;**

s) In violation of 77 Ill. Admin. Code, Ch. I, §300.1810(b), failed to ensure that the staff accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

t) In violation of 77 Ill. Admin. Code, Ch. I, §300.3240 failed to ensure that the staff protect ODILA from abuse and/or **neglect**;

u) Failed to ensure that the staff develop, implement and revise an up-to-date care plan to meet ODILA's needs including, but not limited to, her risk for the development and deterioration of pressure sores;

v) Failed to ensure that the staff appropriately assess ODILA's risk for the development of pressure sores and the worsening of existing pressure sores;

w) Failed to ensure that the staff provide appropriate medical care to ODILA when it was known or should have been known that such care was needed;

x) Failed to ensure that the staff timely provided preventative measures including, but not limited to, adequate turning and repositioning assistance and pressure relief surfaces to prevent the development and progression of pressure sores;

y) Failed to ensure that the staff properly reposition and turn ODILA and apply/utilize pressure relieving measures to relieve existing pressure sores and prevent future pressures sores from developing;

z) Failed to ensure that the staff timely and appropriately re-assess ODILA upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

aa) Failed to ensure that the staff timely and appropriately revise ODILA's care plan upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

bb) Failed to ensure that the staff accurately document ODILAS pressure sore progression and the treatment administered for ODILA'S pressure sores;

cc) Failed to ensure that the staff try new approaches to treat ODILA'S worsening pressure sores; and

dd) Failed to have a proper infection control program that investigates controls and prevents infection in the facility.

17. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, ODILA suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributec to causing her death.

18. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries of a personal and pecuniary nature including, but not limited to, hospital, medical and related expenses, disability and disfigurement, pain and suffering, physical and emotional trauma, and a decline in **ODILA'S** level of dignity, self-respect and individuality; and **ODILA** would have been entitled to receive compensation from Defendant for these injuries had she survived. Further, **ODILA'S** estate was diminished by virtue of the medical and hospital expenses that were incurred.

19. Attached to this Complaint as “Exhibit C” is the Affidavit of the Attorney in this cause and Health Professional's Report, filed pursuant to 735 ILCS 5/2-622(a)(1).

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **MAURA OSORTO, RN,** in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00).**

COUNT XI

Berenguer v. Maura Osorto, RN (Negligence – Wrongful Death)

1. **DENISE BERENGUER** has been appointed as the Independent Administrator of the **Estate of ODILA BERENGUER,** Deceased. (See Letters of Office attached as Exhibit A).

2. The Plaintiff, DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased, brings this action pursuant to the provisions of 740 ILCS 180/1-6 et seq., commonly known as the Illinois Wrongful Death Act.

2. **ODILA BERENGUER** (hereinafter **“ODILA”**) was born on XX/XX/1927.

3. **ODILA** died on October 14, 2012.

4. **ODILA** was a resident of the long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY (“the Facility”)** from approximately March 22, 2012 through August 2, 2012, with intermittent hospitalizations.

5. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** was a Registered Nurse, licensed by the State of Illinois.

6. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** was employed as the Director of Nursing for long-term care facility commonly known as **CENTER HOME FOR HISPANIC ELDERLY.**

7. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** was acting as an actual, apparent and/or implied agent, servant, and/or employee of the Defendant, **CENTER HOME FOR HISPANIC ELDERLY, LLC, an Illinois Limited Liability Company d/b/a CENTER HOME FOR HISPANIC ELDERLY.**

8. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** was acting within the scope of her employment and/or agency relationship with the Defendant, **CENTER HOME FOR HISPANIC ELDERLY.**

9. At all times relevant to this Complaint, **ODILA'S** overall condition clinical condition required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

10. At all times relevant to this Complaint, the Defendant, **MAURA OSORTO, RN,** knew or should have known that **ODILA** was at risk for the development and deterioration of pressure sores and that she required supervision and assistance with activities of daily living to ensure that she was receiving proper care and treatment to prevent the development and deterioration of pressure sores.

11. Upon admission to **CENTER HOME FOR HISPANIC ELDERLY** on March 22, 2012, **ODILA** was assessed at a high risk for skin breakdown.

12. During the course of her residency at **CENTER HOME FOR HISPANIC ELDERLY, ODILA** developed multiple pressure sores, which became infected, requiring hospitalizations.

13. Pursuant to 77 Ill. Admin. Code, Ch. I §300.1220, as the Director of Nursing, **MAURA OSORTO, RN,** had a duty to supervise and oversee the nursing services provided at **CENTER HOME FOR HISPANIC ELDERLY.**

14. At all times relevant to this Complaint, it was the duty of the Defendant, **MAURA OSORTO, RN,** to use the skill and care ordinarily used by a reasonably well-qualified director of nursing in the supervision of the nursing staff providing care and treatment to **ODILA.**

15. Notwithstanding, the Defendant, **MAURA OSORTO, RN,** breached her duty aforesaid and was negligent as a result of one or more of the following negligent acts or omissions:
a) In violation of §483.13(b) and (c) of the OBRA REGULATIONS, failed to protect ODILA from abuse and neglect by failing to ensure that the staff appropriately developed, implemented and revised a care plan to address ODILA's risk for the development and deterioration of pressure sores;

b) In violation of §483.15(a) of the OBRA REGULATIONS, failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, including ODILA, in full recognition of his individuality;

c) In violation of §483.13(b) and 483.20(b) of the OBRA REGULATIONS, failed to ensure that the staff appropriately assessed ODILA's overall clinical condition, skin integrity and risk for the development and worsening of pressure sores, upon admission to the facility;

d) In violation of §483.20(g) of the OBRA REGULATIONS, failed to ensure that the staff accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

e) In violation of §483.20(h) of the OBRA REGULATIONS, failed to have adequately trained nursing staff conduct and coordinate ODILA's assessments;

f) In violation of §483.20(k) of the OBRA REGULATIONS, failed to ensure that the staff objectively observe, assess and evaluate changes in ODILA's condition including, but not limited to, ODILA's skin integrity;

g) In violation of §483.25(a) of the OBRA REGULATIONS, failed to ensure that the staff provide the necessary care and services to prevent a decline in ODILA's abilities to perform activities of daily living;

h) In violation of §§483.25(c)(1) and 483.25(c)(2) of the OBRA REGULATIONS, failed to ensure that the staff provide necessary treatment and services to avoid the development of pressure sores, promote healing of pressure sores, and prevent infection and development of new pressure sores;

i) In violation of §483.25 of the OBRA REGULATIONS, failed to ensure that the staff provided care and treatment to ODILA to allow her to attain or maintain the highest practical, physical, mental and psycho social well-being;

j) In violation of §483.65(a) of the OBRA REGULATIONS, failed to have a proper infection control program that investigates, controls and prevents infection in the facility;

k) In violation of §483.75(b) of the OBRA REGULATIONS, failed to operate and provide services in compliance with all applicable professional standards by including, but not limited to, inadequate documentation in ODILA's clinical record, failure to update her care plan and failure to institute appropriate nursing interventions to promote skin integrity;

1) In violation of 77 IlI. Admin. Code, Ch. I, §300.1210(a), failed to ensure that the staff provide ODILA with the necessary care and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being in accordance with ODILA's comprehensive assessment and plan of care;

m) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a)(1), failed to ensure that the staff provide ODILA with appropriate restorative and rehabilitative measures to meet her individual needs;

n) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(a)(4), failed to ensure that the staff assist and encourage ODILA so that her abilities in daily living activities did not diminish;

o) In violation of 77 Ill. Admin. Code, Ch I, §300.1210(b)(3), failed to ensure that the staff provide objective observations of changes in ODILA's condition, as a means for analyzing and determining the care required and the need for further medical evaluation and treatment;

p) In violation of 77 III. Admin. Code, Ch. I, §300.1210(b)(5), failed to ensure that the staff provide ODILA the necessary care and services to promote healing, prevent infection and prevent pressure sores from developing;

q) In violation of 77 Ill. Admin. Code, Ch. I, §300.1210(b)(6), failed to ensure that the staff take all necessary precautions to assure that ODILA's environment remained as free of accident hazards as possible;

r) In violation of 77 Ill. Admin. Code, Ch. I, §300.1220(b)(3), failed to ensure that the staff develop, implement and revise an up-to-date care plan for ODILA based on her comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs;

s) In violation of 77 Ill. Admin. Code, Ch. I, §300.1810(b), failed to ensure thai the staff accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

t) In violation of 77 Ill. Admin. Code, Ch. I, §300.3240 failed to ensure that the staff protect ODILA from abuse and/or **neglect**;

u) Failed to ensure that the staff develop, implement and revise an up-to-date care plan to meet ODILA's needs including, but not limited to, her risk for the development and deterioration of pressure sores;

v) Failed to ensure that the staff appropriately assess ODILA's risk for the development of pressure sores and the worsening of existing pressure sores;

w) Failed to ensure that the staff provide appropriate medical care to ODILA when it was known or should have been known that such care was needed;

x) Failed to ensure that the staff timely provided preventative measures including, but not limited to, adequate turning and repositioning assistance and pressure relief surfaces to prevent the development and progression of pressure sores;

y) Failed to ensure that the staff properly reposition and turn ODILA and apply/utilize pressure relieving measures to relieve existing pressure sores and prevent future pressures sores from developing;

z) Failed to ensure that the staff timely and appropriately re-assess ODILA upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

aa) Failed to ensure that the staff timely and appropriately revise ODILA's care plan upon a significant change in condition including, but not limited to, the development and progression of pressure sores;

bb) Failed to ensure that the staff accurately document ODILA'S pressure sore progression and the treatment administered for ODILA'S pressure sores;

cc) Failed to ensure that the staff try new approaches to treat ODILA'S worsening pressure sores; and

dd) Failed to have a proper infection control program that investigates controls and prevents infection in the facility.

16. As a direct and proximate result of one or more of the Defendant's statutory violations and/or negligent acts or omissions, **ODILA** suffered injuries including, but not limited to, a deterioration of her physical and mental condition, a loss of dignity and respect and the development and deterioration of multiple pressure sores, including Stage IV pressure sores of the bilateral elbows, which became infected requiring hospitalizations and debridement, all of which caused or contributed to causing her death.

17. All of **ODILA'S** next of kin suffered injuries as a result of her death including, but not limited to, the loss of companionship and society and grief, sorrow and mental anguish. Further, **ODILA'S** estate was diminished by virtue of the medial and hospital expenses that were incurred.

18. **ODILA** left surviving her, various persons who were here next of kin, including, but not limited to, the following individuals:

a. Denise Berenguer (daughter);

b. Lilliana Caraballo-Butcher (daughter); and

c. Miguel Laboy (son).

19. Attached to this Complaint as “Exhibit C” is the Affidavit of the Attorney in this cause and Health Professional's Report, filed pursuant to 735 ILCS 5/2-622(a)(1).

WHEREFORE, the Plaintiff, **DENISE BERENGUER, as Independent Administrator of the Estate of ODILA BERENGUER, Deceased,** prays that this Honorable Court enter a judgment against the Defendant, **MAURA OSORTO, RN,** in a fair and just amount in excess of **FIFTY THOUSAND DOLLARS ($50,000.00).**

Respectfully submitted,

LEVIN & PERCONTI

BY:

Attorneys for the Plaintiff

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